PRINTED: 7/31/2023 FORM APPROVED 2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396134		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 08/03/2022	
NAME OF PROVIDER OR SUPPLIER: PENN STATE HEALTH TRANSITIONAL CARE  STATE LICENSE NUMBER: 21700201			STREET ADDRESS, CITY, STATE, ZIP CODE: 1135 OLD WEST CHOCOLATE AVENUE, 2ND FLOOR HUMMELSTOWN, PA 17036				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICI MUST BE PRECEEDED BY FULL REGULATORY OR LS IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0000	Based on a closure survey completed on August 3, 2022, at Penn State Health Transitional Care, it was determined that the facility voluntary closed and is no longer participating in the Medicare/Medicaid programs under 42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities and is no longer licensed as a long term care nursing facility under the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.		F 0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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## **Certified End Page**

## PENN STATE HEALTH TRANSITIONAL CARE

STATE LICENSE NUMBER: 21700201 SURVEY EXIT DATE: 08/03/2022

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

## **PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY